Communication Release

3/1/2024

Training Opportunities: Connecting Clinical Documentation to Medi-Cal Billing Codes

SAPC's Clinical Standards and Training (CST) unit is hosting two Continuing Educational (CE) eligible trainings focused on connecting clinical documentation to the expanded HCPCS/CPT billing codes available under payment reform. One training is specifically geared toward LPHAs and License Eligible (LE) LPHAs, while the other training is dedicated for counselors and certified peer support specialists.

Training Date/Time	Training Name	Audience	Links
Monday, 3/4/2024, 9:00 am – 11:30 am	Connecting LPHA Clinical Documentation to Medi-Cal Codes	– LPHA (CE eligible) – LE-LPHA – Finance/billing staff welcome	Flyer- for more information Registration – required for attendance
Monday, 3/11/ 2024, 9:30 am – 12:00 pm	Connecting Clinical Documentation to Medi-Cal Codes for Counselors and Certified Peers	– AOD counselors (CE eligible) – Certified Peer Support Specialists (CE eligible) – Finance/billing staff welcome	Flyer- for more information Registration -required for attendance

Notice to Resubmit State Denials for Code B7

Some providers may have recently received State denials for denial code B7 with or without a RARC. These denials are due to the wrong NPI being entered in Sage or the NPI being incorrectly entered on the State record. SAPC manages the process for providers to maintain Sage and the State's record upon notification of NPI's changing and resubmits the services for adjudication to DHCS. An unintended change in Sage led to recent State denials for this issue to be recouped from providers and has been corrected. If an agency has received recent State denials for this code, please resubmit the service to SAPC. No changes are required by the provider to fix this denial.

Sage Address for Patients Experiencing Homelessness

It is DPSS policy to use the District Office for those who do not have a mailing address as indicted in DPSS form PA 1815. This is specific to recipients of DPSS program benefits (Medi-Cal, CalWORKs, General Relief, Refugee Cash Assistance, CalFresh, Cash Assistance Program for Immigrants) and is limited to DPSS and official government mail only.

As stated in SAPC's Provider Manual:
"Treatment providers should utilize the Care Coordination benefit to assist patients with obtaining and maintaining Medi-Cal or other benefits throughout the SUD treatment and recovery process, patients will need to provide their new physical and mailing addresses (for people experiencing homelessness this may include the DPSS District Office, provider address as permissible by agency policy, or other designated mailing address) and primary contact number."

Please include a mailing address as described above, when completing a patient's Financial Eligibility form, in the "Subscriber's Address" fields. Entering values that are not a mailing address (such as homeless, transient, unknown, or any entry that is not a physical or mailing address) may cause delays in timely submission of claims to the State as the address must be updated to fit one of the allowable address options per DHCS.

REMINDER: Group Counseling and Patient Education for FY 22-23

SAPC recently became aware of a Sage configuration issue causing some group counseling and patient education services for FY 22-23 to be denied by DHCS for CO 96 N362. These services were recently billed to DHCS by SAPC and were recouped by SAPC in November and December 2023. SAPC is working with Netsmart to identify a resolution in Sage to prevent further denials. While SAPC works to resolve this issue, SAPC requests that providers temporarily hold submitting original or resubmitted claims for group counseling and patient education services delivered for FY 22-23 until the configuration can be updated. SAPC will notify the network as soon as a resolution has been implemented.

Published: 1/5/2024

Sage-PCNX Form, Report, and Widget Updates

The SAPC Sage Team would like to announce the following updates:

Form/Report/Widget	Changes	Environment	Date Available
Problem List/Treatment Plan Reminder Widget	****NEW**** The Problem List/Treatment Plan Reminder Widget will be added to PCNX Clinical and Financial + Clinical Views to allow providers to more easily track upcoming review and update dates for Problem Lists and Treatment Plans. The widget includes necessary fields to quickly assess due dates. The widget will populate all problem lists/treatment plans with a Tx Plan Date within the previous 45 days. There is additional logic for color coding of the Next Review and Update Due Date fields as follows: 1. To show as red if the dates are 7 days past due from the current date or due the following day. 2. To show as orange if the due dates are between 2 to 7 days from the current date. 3. To show as green if the due dates are between 8 days and 30 days from the current date. The Problem List/Treatment Plan Reminder Report can be used to search for the complete list of PL/TPs by any date range for more thorough review.	LIVE and TRAIN	Monday 3/4/24
Progress Note (form)	A **Service Duration (minutes)** field was added to capture the direct patient service time which may be less than the total difference of the Service End/Start time. Please click on the light bulb next to the field on the form for additional information.	TRAIN	Available now
270 Inquiry Widget	Updated to populate the most recent data first to ensure the current information is showing. The widget captures up to twelve 271 responses based on the most recent Submission Date field that were run in the last 12 months.	LIVE	Friday 2/16/2024

For questions regarding using the updated forms, reports, and/or widgets, please email Sage@ph.lacounty.gov.

Reminders From Prior Sage Provider Communications:

Sage Provider Communication February 16, 2024

State Denial CO 97 M86: Providers may have started to receive State denials with code CO 97 M86 for services delivered for FY 23-24. The Department of Health Care Services' (DHCS) description for this denial is, "Short-Doyle Medi-Cal denied this service because it had already approved the same service provided on the same day, by the same rendering provider, to the same beneficiary." DHCS's denial description is referring to their policy on Outpatient Services that requires providers to submit one service that incorporates two or more services (as allowed) into one claim for FY 23-24. This is different than how providers should continue to bill for FY 22-23 services. SAPC Finance's investigations into this denial code have confirmed that some providers are continuing to bill SAPC with two separate services/claims for, for example, claiming two individual counseling services instead of rolling up the two services into one. The information regarding this denial will be added to the next version of SAPC's Denial Crosswalk.

Resolution

- **Primary Sage Users:** Void the original service billed to SAPC that was not denied by DHCS. Resubmit the service with the two (or more) services rolled up into one service with the units totaled.
- **Secondary Sage Users:** Submit a replacement claim for the original serviced billed to SAPC that was not denied by DHCS. Resubmit the service with the two (or more) services rolled up into one service with the units totaled.

Below is the information from the DHCS Billing Manual, a clarification email from 8/1/2023 from SAPC on Roll-Up Services, and an update from the Sage Provider Communication from 9/29/2023 which provides an update on roll-up services and group counseling/patient education.

DHCS DMC ODS CalAIM Billing Manual, page 32, section 5.2.12 on Duplicate Services – Outpatient Services

"Outpatient services are listed in service tables 1-13. Except for Sign language or Oral Interpretive services (T1013), Interactive complexity (90785), and health behavior interventions for the family without the patient present (96170 and 96171), a claim is considered a duplicate if all of the following data elements are the same as another service approved in history:

- The beneficiary's CIN
- Rendering provider NPI
- Procedure code(s)/modifier(s)
- Date of service

Duplicate services are not allowed.

If a provider renders the same service to the same beneficiary on the same day more than once, the provider should submit the claim as one service rather than two services. For example, a provider may render 60 minutes of recovery services in the morning and an additional 30 minutes of recovery services in the evening to the same beneficiary. In this particular scenario, the county would submit one claim for 90 minutes of recovery services."

SAPC Email to Providers on 8/1/2023

"For FY 23-24, providers are required to submit same services (those with the same HCPCS or CPT Code), occurring on the same day, and performed by the same performing provider to the same patient as a consolidated single claim. This is known as a roll up service. For example, a performing provider who provides 30 minutes of care coordination in the morning (onsite) and 30 minutes of care coordination (via telephone) in the afternoon to the same patient on the same day, must claim this as one claim of 60 minutes of care coordination for the day. Providers who fail to do this will receive a denial on the claim once adjudicated by the State."

Sage Provider Communication on 9/29/2023

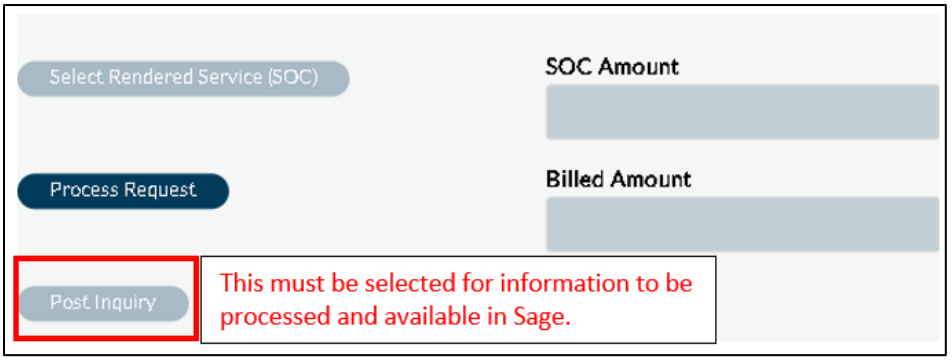
"*Updated DHCS Policy on Roll-Up Services for Groups: After successfully advocating for our providers with DHCS, the State has removed the requirement for multiple group services/patient education groups delivered to the same patient on the same day to be "rolled up" or combined into one service for billing. Providers can once again bill each service separately as in previous fiscal years. The requirement is still in effect for all individual services and must be rolled up into one total service, such as for multiple individual counseling, assessments, or care coordination, etc. delivered to the same patient in the same day by the same provider."*

Updated Assessment Claiming Guidance: SAPC has received recent clarification from DHCS and Medi-Cal regarding the assessment codes H0001, 90791, and G2212 prolonged service code. SAPC recommends use of H0001 for all assessments completed by non-medical LPHAs and discontinue use of 90791 with the G2212 add on code. The rate for each of these codes is identical where providers will be paid the same amount for H0001 and will no longer require use of G2212. H0001 does not have the 1-unit max per day restriction and will allow the full service time in units on the same claim.
Medical LPHAs, such as MDs/DOs/PAs, etc. will continue to use G2212 as needed if the primary CPT code does not cover the full duration of the service.

Peers Support Specialist Scholarship Availability: SAPC released a Certified Peer Support Specialist Scholarship Application and scholarship manual for interested Peer candidates. Scholarships are limited and available until all funds are exhausted or December 31, 2025, whichever comes first. Direct any questions to SAPC_ASOC@ph.lacounty.gov.

Certified Medi-Cal Peer Support Specialists access to the Problem List: Certified Medi-Cal Peer Support Specialists (CMPSS) received access to edit a patient's Problem List/Treatment Plan form in Sage on 2/19/2024. However, it is still required to be finalized by an (LE)LPHA. For additional resources on what can be entered into a Problem List, please refer to the CalAIM Documentation Reform section of the SAPC Sage website.

Real Time Eligibility 270 Inquiry Workflow: SAPC has identified a workflow issue where providers are not posting the results of the Real Time Eligibility 270 Inquiry form in Sage after viewing the report. Failure to post results prevents the data from being available to populate the reports and widgets used to view the aid and county codes from the 271 results. Previously, in ProviderConnect-Classic, posting was required before the report would populate; however, in PCNX posting is not required for the report to display, which allows the user to leave the page before posting without receiving a warning message. It is very important to post the file to ensure the data is available for all subsequent providers and available to you on the widgets and reports. Specifically, by using the 270 Eligibility report to post the results, the County and Aid Code Report and/or the 270 Inquiry widget, which is viewable on the Client Dashboard, will help to determine DMC eligibility.



SAPC does not have an update for when the issue related to the error on the eligibility report will be resolved. However, the data is being transmitted and available after posting on the widget and the County and Aid Code report in PCNX for providers who post the inquiry results.

Midpoint Rule and Billing Rolled Up Services: When multiple services are provided to the same patient, on the same day, by the same practitioner, with the same service code, these should be rolled up and billed as one service to SAPC.

DHCS uses AMA rules, which states that each service must meet the midpoint rule independently to qualify to be **included in the billing** as a roll up. Units billed should not be based on the combined total duration time but on each individual service duration time meeting the midpoint rule.

Example 1:	Service 1 = 18 mins (meets midpoint rule) Service 2 = 7 mins (*does <u>not</u>* meet midpoint rule)	Combined Total Duration: 25 mins **Allowable Units Billed: 1 unit**
Example 2:	Service 1 = 9 mins (meets the midpoint rule) Service 2 = 8 mins (meets the midpoint rule)	Combined Total Duration: 17 mins **Allowable Units Billed: 2 units**